State Seal

STATE OF INDIANA
VERIFICATION OF FULL TIME STUDENT ON A MEDICAL LEAVE OF ABSENCE

State Form XXXXXX
(Pending Approval)

Currently, dependent children covered by the State of Indiana Health, Dental and Vision are eligible for coverage until the end of the calendar year of their 19th birthday. Coverage for Health, Dental and Vision plans may extend beyond this limiting age if the dependent is a full-time student of a postsecondary educational institution.

Federal law requires health plans to maintain coverage for students who are unable to continue attendance at their postsecondary educational institution as a result of a medical leave of absence. If your dependent meets the requirements for a medical leave of absence, then that dependent's coverage shall not be terminated before the date that is the earlier of:

- the date that is 1 year after the first day of the medically necessary leave of absence; **or**
- the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage. *(H.R. 2851: Michelle's Law, 2008)*

To apply for a continuation of coverage under this exception, this form must be completed by the employee as well as the dependent's attending physician.

Upon completion, please mail this form to:
State Personnel Department, Benefits Division
402 West Washington Street, Room W-161
Indianapolis, IN 46204.

You may also fax this form to 317-232-3011.

TO BE COMPLETED BY EMPLOYEE

Employee Name_____ **Employee ID**: 10000 ☐☐☐☐☐☐

Dependent Name_____ **Dependent DOB** ☐☐-☐☐-☐☐

Relationship to Employee _____

To be eligible for the exception made by Federal Law H.R. 2851, your dependent must have been enrolled on the State of Indiana health plan(s) on the basis of being a full-time student of a postsecondary educational institution **immediately before** the medically necessary leave of absence began.
Does your dependent meet this guideline? Yes_____ No_____

Dates enrolled full-time:
Beginning Date**:** ☐☐-☐☐-☐☐
Anticipated End Date**:** ☐☐-☐☐-☐☐

Date the medical leave began: ☐☐-☐☐-☐☐

Name of college, university, or other educational institution_____

It is required that dependent's attending physician documents the illness and certifies the medical necessity of the educational leave of absence.

TO BE COMPLETED BY ATTENDING PHYSICIAN

Patient (Dependent) Name_____

Diagnosis:_____

_____

Date condition was first diagnosed: ☐☐-☐☐-☐☐

Is a leave of absence from the patient's postsecondary educational institution *medically necessary*?

☐ Yes ☐ No

Comments_____

_____

_____

Signature of Attending Physician *(Required)* Degree Date

_____

Printed Name of Physician

_____

Address City State Zip Code

AFFIRMATION

The undersigned insured person applies for continuation of said dependent's insurance. The insured person understands that continuation of coverage due to medically necessary leave of absence from their postsecondary educational institution is subject to approval by the insurance carriers and that continuous coverage is subject to written request having been made by January 1 of the year following the manifestation of the disability.

In making this application I understand that acceptance of continuation of coverage by the insurance carriers shall in no way affect regular termination provisions of the policy and that said dependent's coverage shall terminate at such time that the insured person's coverage terminates. I hereby certify that the above statements are true to the best of my knowledge and belief. I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be disciplined and may be guilty of a crime.

I further authorize any physician, hospital organization, or insurance company to furnish any information required in regard to granting this application. A copy of this authorization shall be considered as valid as the original.

_____ _____

Employee's Signature Date